SI ref: **SI619**

Divisional lead for action plan: Dr Christine Gregson (Interim Clinical Lead Acute Medical Unit) / Dr Ben Killingley (Clinical Lead Acute Medicine)

Duty of candour lead: Christine Gregson, Consultant Physician & Interim Clinical Lead Acute Medical Unit / Daniel Wallis, Consultant in Emergency Medicine & Governance Lead Emer

Recommendation	SMART actions	Priority / Due date:	Responsible person	Evidence	Monitoring (e.g. audit)	Completed date:	Trust-wide learning Y/N	Update
1. Guidance on the care of patients with hyponatraemia to be reviewed at local Clinical Governance meetings (Acute Medical Unit and Emergency Department).	Current (national / international) and future (Trust) guidance on the care of patients with hyponatraemia to be reviewed at local Clinical Governance meetings (Acute Medicine and Emergency Department).		1	· ·	Emergency Services Divisional Quality & Safety Board	ED: 19/11/2021	Υ	
2. Creation of a guideline on hyponatraemia for the Trust's Medical Emergency Document Library.	_		Dr Marc George	available in the Trust's intranet	Emergency Services Divisional Quality & Safety Board		Υ	
3. and 4. Ensure formal teaching on the care of patients with neurological presentations - and in particular patients with altered mental state / behaviour - and on hyponatraemia is included in the rolling training programmes in Acute Medicine and Emergency Medicine.		2022	ED: Dr Dipak	Acute Medicine and	Emergency Services Divisional Quality & Safety Board		Υ	

5. Review of the patient's initial CT	The patient's initial CT scan to be added	High / January		Review of the	Imaging Clinical			
scan at the Imaging Department's	to the agenda for review, and learning	2022		patient's CT head	Governance			
Learning Meeting.	shared, at the Imaging Department's			scan on Imaging	committee			
	Learning Meeting.			Department's				
				Learning Meeting			N	
				agenda, and				
				outcome reflected in				
				the meeting				
				minutes.				
	Findings of the updated SI report to be	High / February	Ms Cathy Mooney,	Report sent, and	Quality &	Original SI report		
	shared with the patient's mother, and	2022	Director for	meeting with	Safety	sent on		
	Duty of candour completed.		Quality & Safety	clinicians offered.		10/12/2021, and		
				Duty of candour		offer of meeting		
				documentation in		made on	N	
				Epic EHRS and in		10/12/2021 and		
				Datix incident		06/01/2022.		
				reporting system.				